GARRETT SPINE, NERVE & PAIN CENTER

90 Main Street

Westernport MD, 21562

Ph: 301-616-2550

Fax: 301-359-5057

Your appointment is _____ at _____.

Your arrival time on _____ is at _____.

Dear Patient,

Thank you for choosing Garrett Spine, Nerve, & Pain Center for your pain management needs. Bring the following items to your new patient consult:

- ✓ Drivers License (or other government issued form of identification)
- ✓ **ALL** Insurance cards (primary insurance, secondary insurance, etc)
- ✓ **ALL** attached new patient paperwork and consents **completed and signed.**

If you do not have the items listed above at the time of your appointment, you may be asked to reschedule.

It is important for all new patients to arrive 30 minutes prior to their scheduled appointment time to allow time for front office staff to obtain needed information as well as for the clinical staff to review and input the information from the attached paperwork. Please arrive at your appointment at the **highlighted arrival time** listed above.

If you are unable to make your scheduled appointment, please contact the office at 301-616-2550 at least 48 hours in advance and appointments cancelled or rescheduled less than 48 hours will result in a fee. All attendance policies and the fees associated with missed appointments are detailed within this packet. **Please carefully read ALL consents and policies** of Garrett Spine, Nerve, & Pain Center failure to adhere to policies outlined in this packet could result in discharge from the practice.

GSNPC
GARRETT SPINE, NERVE & PAIN CENTER

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____ Date of Birth: ____/____/____

Address: _____

Phone Number: _____ SSN: _____

I authorize the custodian of records of: _____ or other person/entity (specifically describe) _____ to disclose/release the following information* (mark all that apply)

- ☐ All records
- ☐ Laboratory/Pathology Results
- ☐ X-Ray/Radiology/Imaging Records
- ☐ Billing
- ☐ Abstract/Summary
- ☐ Pharmacy/Prescription Records
- ☐ Other (describe specifically) _____

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, behavioral health, or sexually transmitted diseases, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if needed)

Name: _____

Address: _____

Phone: _____

Fax: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize this use or disclosure of this protected health information.

_____ _____

Signature of patient or representative Date

_____

Printed Name

GARRETT SPINE, NERVE & PAIN CENTER

Name: _____ Date of Birth: _____

Referring Provider: _____

Pharmacy: _____

Chief Complaint: _____

Circle all that apply regarding your pain:

chronic acute sudden gradual trauma related intermittent constant sharp
shooting stabbing radiating aching dull throbbing numbness & tingling

Please list TWO activities that aggravate your pain.

1. _____ 2. _____

Have you had any recent imaging completed? (Xray, CT Scan, MRI) NO YES If yes, when was the imaging performed and which facility was the imaging completed at? _____

Have you previously attended Pain Management? NO YES If yes, please provide the following information:

Name of Pain Management/Provider: _____ Date of last visit: _____

Reason for leaving: Discharged due to noncompliance Transportation Issues No longer accepting insurance/cost Ineffective treatment plan Other: _____

PREVIOUS TREATMENT FOR PAIN

Physical Therapy	Heat/Ice	Accupuncture	Chiropractor	TENS Unit
Home Exercise	Injections	Dry Needling	Medication	Other

If other, please explain _____

Did any of the previous treatments for your pain provide you with adequate pain relief? NO YES

If yes, please indicate which treatment _____

ALLERGIES – Please list all medication allergies and reactions.

Medication Name	Reaction

Are you allergic to latex? No Yes

CURRENT MEDICATIONS – if you have a medication list please provide a copy at your appointment. If you do NOT have a current medication list please list all medications including dose and frequency below.

Are you currently taking a blood thinner? NO YES _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SURGICAL HISTORY:

_____ _____

_____ _____

_____ _____

PAST MEDICAL HISTORY (circle all that apply)

Anxiety	Heart Attack	Stroke
Depression	COPD	Asthma
Arthritis	Diabetes	Allergies
HTN	Edema	Migraines
GERD	Hypothyroidism	Coronary Artery Disease
Hepatitis	Kidney Disease	Liver Disease
Neuropathy	Osteoporosis	Seizures
Cancer _____	Alcoholism	Substance Use Disorder

Other: _____

FAMILY HISTORY

	Alive or deceased	Cancer	Diabetes	Alcoholism Substance Use	Heart Disease	HTN	Stroke	Thyroid Disease	Mental Illness
Father									
Mother									
Siblings									

Other Notable Family History/Explanation of checked boxes if needed:

_____

_____

SOCIAL HISTORY:

- Tobacco Use - current _____packs per day former smoker never/nonsmoker
  - If former smoker please list quit date _____
- Alcohol Use - NO YES if yes, how many drinks per day _____.
  - _____ cans of beer _____ glasses of wine _____ shots of liquor
- Substance Use - current use former use never
  - Substances used and frequency of use _____

    _____

    If former substance use, please list quit date _____